Australian Universities Accord Interim Report - Australian Council of Deans of Health Sciences

ACDHS supports the Accord aim, to increase equity of opportunity, meet future skills needs and deliver high quality research that is useful to communities, industry and governments. We also support the Accord process aims of rapidly increasing university places. Given the health workforce shortages and projected growth needs there is a critical need to grow the number of university places available in professional entry allied health degrees. This submission focuses on 5 key areas:

1. Clinical Placements and WIL – availability.
2. Clinical Placements – costs to undertake.
3. Accreditation Burden – duplication and inefficiency.
4. Academic Workforce – training graduates.
5. Allied Health Research – developing innovative models of care.

1. Clinical placements and work opportunities in health

Support for compulsory placements

We *cannot* widen participation and grow university places in the allied health disciplines without opening up more - and more diverse - clinical placements. Generation of additional placements will require Education, Health, Professional Bodies, Accreditation authorities, Regulators and different levels of federal and state governments to work together as a matter of national importance. ACDHS members are reluctant to increase student numbers in health degrees without a specific way forward that addresses the supply, diversity and costs of clinical placements. While we agree with the aims of the Accord, to increase student places at university this will be difficult to achieve in health degrees with compulsory clinical placement requirements.

The lack of clinical placements in many health, disability and aged care settings, combined with the competition for placements between institutions, are constraining the growth of the allied health workforce nationally. The cost of placements for universities has increased. A national approach to reducing the duplication and waste in accessing and administering and supporting placements would help to improve accessibility and supply.

Widening participation for students from diverse backgrounds that reflects our diverse community is particularly important in health professions education (HPE): access to culturally appropriate care affects positive health outcomes. These students may need different types and levels of support to complete compulsory clinical placements.

Opportunities for students to work in their field of study.

ACDHS support working with industry/health services to enable students to access more paid work opportunities in their study fields. It is important to note, these work opportunities cannot replace clinical placements or WIL experiences that are intentionally designed to build capability and competence towards independent practice. When students are in an employment relationship, employer priorities may supersede the critical learning that students need. Consequently, guidelines and frameworks for employers and universities are required to support paid work opportunities for health students.

We recommend 1) the collaborative development of a framework and guidelines for paid employment of allied health students in the sector 2) development of a national database of placements 3) smart digital solutions to reduce waste and administration of clinical placements for universities and placement providers nationally across the health, disability, education, aged care and private sector 4) the continued development, updating and placing on digital platforms of national assessment tools for allied health students to promote student mobility and willingness for placement sites to accept students from multiple universities and assure the competency of graduates nationally 5) development and support of a national placement student feedback tool similar to the one

created for nursing students. The above five initiatives will make progress on reducing waste and effort and create efficiencies and opportunities for student placement experiences nationally.

We recommend funding to higher education institutions to enable the provision of foundation support for students to undertake compulsory placements. For example, through the provision of safe, affordable accommodation and transport. Similarly, we recommend equal access to rural clinical experiences for domestic and international students through the Rural Health Multidisciplinary Training Scheme. Currently international allied health students many who remain working in Australia after completing their degrees, are not supported to access accommodation and other facilities available to domestic students.

We recommend that funding to develop and evaluate new placement models in emerging areas of allied health workforce be established to develop and support new placement contexts. Tax incentives for organisations that take allied health students on placement is a potential way to encourage new placement opportunities.

Allied health students entering the future workforce will need different and additional skills to current graduates. However, universities will need assistance to ensure that students receive practical experience in emerging areas of practice that will increasingly require an allied health workforce. Two areas are primary care and aged care.

In the case of aged care there are so few allied health professionals working in aged care it is currently impossible for an adequate volume of students to gain supervised practical experience in this context in order to meet demand over the next decade. Currently funding models do not support supervision and integration of allied health students in aged care contexts. New models of care that include allied health student education are required urgently to address this need.

We recommend new funding to pilot and evaluate multidisciplinary allied health models of service delivery and student placement models in aged care to ensure a well-educated workforce is available and wanting to work in aged care in the future.

Similarly, the education of allied health students in primary care contexts is not funded unlike the education of medical students. In fact, taking an allied health student on placement may reduce revenue of primary care allied health professionals as they are unable to claim services delivered by students on Medicare and many other funding sources even though they are supervised by qualified professionals. Currently there are no feasible, sustainable models of ways to include allied health students in the delivery of these models.

We recommend reform of Medicare to allow primary care allied health practitioners to claim for services delivered by students under supervision to support the education of the future allied health workforce that will be needed

2. Cost to undertake clinical placements.

Placement poverty is a real and growing issue, and ACDHS support stipends/bursaries for all health students who face cost-of-living challenges on compulsory placements. Table 1(Appendix) provides examples of the length of placements required in some allied health professions. The placements required to complete degrees as per accreditation requirements can place students in a position of financial hardship. If we meet new equity and diversity targets for students in higher education, then we expect that the proportion of students who experience placement poverty will increase. There are three potential solutions to this issue:

1. Make Youth Allowance, Austudy and Abstudy available to students while on placement even if they normally do not meet the standard eligibility.
2. Introduce tax incentives for organisations that take final year students on placement and then require those organisations to pay students a stipend.
3. At a national level do not allow payment for placements and divert the funds spent on payment for placements to payments to support students on placement

[1] Christine Morley, Lisa Hodge, Joanne Clarke, Heather McIntyre, Jennifer Mays, Jennie Briese & Tina Kostecki (2023) 'THIS UNPAID PLACEMENT MAKES YOU POOR': Australian social work students' experiences of the financial burden of field education, Social Work Education, DOI: 10.1080/02615479.2022.2161507

3. Accreditation is inefficient and an excessive burden on universities.

We note the Accord Interim report identifies the need to reduce duplication between ASQA and TEQSA. Considerable duplication of standards and processes also exists between TEQSA, AHPRA and accrediting bodies. This hinders Australia's ability to meet health workforce challenges by imposing unnecessary regulatory burden on universities. This in turn reduces the financial viability of allied health courses and diverts resources towards compliance and regulation and away from educational innovation and student experience.

We recommend that TEQSA, AHPRA, the accrediting Councils for registered and non-registered allied health professions, work together to remove duplication, streamline and reduce the regulatory burden of accreditation. We recommend allied health accrediting bodies remove from their accreditation processes the university wide governance, quality, safety and student experience standards required and assessed by TEQSA and focus only on assessing achievement of professional standards through curriculum.

We recommend all inputs-based accreditation standards and evidence of attainment are removed by AHPRA and non-registered accreditation bodies. Only standards and evidence relating to outputs of curricula are allowable.

4. Academic Workforce

A second significant limit to growth in university places in allied health degrees is the supply of a suitably qualified and experienced allied health academic workforce. A constant challenge in allied health, is the tension between pursuing an academic career, maintaining clinical skills and the desire to continue to make a difference in the lives of people. A solution to this is joint appointments between universities and health, disability and aged care providers that allows academics to continue an academic and clinical career. There is strong evidence demonstrating that organisations with clinician researchers achieve better patient outcomes.[2] The added benefit of these arrangements is that the research undertaken is industry embedded, solving real world problems, and is often more easily translated into practice. This approach is aligned with the Accord's call for greater industry input into curricula and research training. There are very few of these types of appointment for allied health academics compared to colleagues in medicine where there is a strong tradition of public health services funding these types of appointments entirely in order to access evidence based, specialist medical services.

We recommend funding incentives for both industry partners and universities to rapidly grow the number and diversity of joint appointments to support expansion of the allied health workforce.

5. Allied health research

The wicked problems facing health care and health systems will require new multidisciplinary perspectives and teams, who are deeply embedded in context so translation to practice and policy is seamless. Australia can leverage its research capacity better by introducing new criteria for grant assessment that takes into account the context of the team and the team members more fully. For example, it could be argued that health and service delivery problems in rural and remote communities are best solved by research teams (potentially in partnership with other universities and communities) embedded in these contexts led by disciplines that have the potential to innovate. Australia can stimulate greater industry investment and engagement with universities by giving additional focus and funding priority to areas of greatest health care need such as aged care and preventative health programs. Using return on investment rationales for research funding will result in more high-quality research leading to cost savings should be given priority for funding.

We recommend that criteria are developed for health services research that includes return on investment metrics. We also recommend that additional research funding is allocated to health service delivery research.

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[2] Boaz A, Hanney S, Jones T, et al Does the engagement of clinicians and organisations in research improve healthcare performance: a three-stage review. BMJ Open 2015;5: e009415. doi: 10.1136/bmjopen-2015-009415

Appendix

Table 1 Placement lengths

Some accreditation standards for allied health degrees mandate minimum hours of clinical placement, for others there is a perceived length of time on placement most students require to meet competency standards. In addition, some accreditation standards require clinical placements across a variety of contexts and/or patient caseloads.

Profession	Placement requirement	Typical Requirement
Physiotherapy	750 – 940 hours	4 or 5, 5 week block placements
Occupational Therapy	1,000 hours	
Social Work	1,000 hours	2 x 13 week block placements
Pharmacy	400-1000 hours	
Podiatry	1000 hours	
Optometry	400-1000 hours	
Speech Pathology	300- 500 hours	3 or 4 x 5-6 week block placements
Sonography	Average of 3 days per week in final year	
Dietetics	500 hours minimum	
Paramedicine	1000 hours minimum	

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